Concepts of Truth, Inc.

Client Services Agreement/Informed Consent

Please let us know if you have concerns about any of these policies. Your first visit will help us get a general understanding of your situation in order to determine how we might best help you. Because we want you to participate actively in planning your counseling, don't hesitate to ask questions.

Psychotherapy is a way of talking through your problems in order to begin resolving them. You will need to take an active part in psychotherapy by working on and thinking about the things you talk about with your therapist. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and feeling much less distressed. However, there are no guarantees of what you will experience, and at times a psychotherapy session may leave you with unhappy feelings.

This form is an Agreement between you and Concepts of Truth, Inc. You may revoke (cancel) this Agreement in writing at any time. That revocation will be binding on Concepts of Truth, Inc. unless we have already relied on this Agreement to take action. This form also contains information about a federal law that affects your privacy rights. This law, called HIPAA (Health Insurance Portability and Accountability Act), regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices (the Notice). The Notice, which is attached to this Agreement, explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Please take home the Notice and read it before your next session; you and your therapist can discuss any questions you may have about it next time.

APPOINTMENTS, HOURS AND LOCATION

Individual appointments last approximately 50 minutes and can be scheduled through your therapist or by calling (**870) 238-4329**. Please leave a message. *If you need to cancel an appointment, notify us at least 24 hours before the session, or you will be charged the per hour session fee.* However, if you call in advance to cancel an appointment because you are ill, there will be no charge.

Concepts of Truth, Inc. office hours are Monday through Friday 8:30-4:00. Appointment availability varies. There are no weekend appointments for individual face to face therapy. Face to Face therapy is conducted in our office at 202 E. Commercial, Wynne, AR with various groups conducted at announced retreat locations. Millie Lace also conducts counseling via technology-assisted methods.

EMERGENCIES

*Although we try to arrange initial counseling appointments promptly, a waiting list may occur during busy times of the year. If you consider your situation an emergency that will not allow delay, please inform our staff. When a therapist is not available or for after hours emergencies, go to the nearest emergency room or call **911**. An emergency is generally a situation in which you are in danger of harm or have hurt yourself or someone else.*

CONFIDENTIALITY AND FILES

We will maintain a Clinical Record file on your case, which is the property of Concepts of Truth, Inc. In most situations, we can release information about your treatment to others *only* if you sign a written authorization form for each release. However, licensed professionals are mandated reporters and there are a few situations where we are required to disclose information to authorities. These situations are listed below:

- If a client is clearly likely to seriously harm him/herself, we may be required to take action to prevent self-destruction.
- If there is a clear risk that a client plans to seriously harm another person, we may have a duty to warn the potential victim; or disclose the risk to appropriate public authorities.
- If a therapist suspects that abuse, neglect, or exploitation of a child or incapacitated adult may have taken place, the therapist is required to report the suspected abuse to the Department of Social and Health Services.
- If a therapist believes someone if engaging or intends to engage in behavior which will expose another person to a potentially life-threatening communicable disease
- If a therapist believes someone's mental condition leaves the person gravely disabled.
- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the counselor-client privilege law. Concepts of Truth, Inc. cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court **orders or subpoenas** Concepts of Truth, Inc. to disclose information, we are required by law to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a client files a complaint or lawsuit against Concepts of Truth, Inc. or any of its staff, Concepts of Truth, Inc. may disclose relevant information regarding that patient in order to defend itself.
- If a client files a worker's compensation claim, the client must sign an authorization so that Concepts of Truth, Inc. may release the information, records or reports relevant to the claim.
- Concepts of Truth, Inc. may present disguised case material in seminars, classes, or scientific writings. In this situation, all identifying information and Protected Health Information is removed, and client confidentiality and anonymity is maintained.

Your signature on this agreement is written, advance consent for the following releases of information:

- Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During consultations, your therapist makes every effort to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. The therapist will note all consultations in your Clinical Record. Also, Millie Lace, MSE, LPC is a supervisor for LAC's and pre/post master's level interns from nearby universities. All interns or therapists will state their level of training or licensure during the initial intake session.
- Your therapist may find it helpful to receive or exchange information with your primary care physician or other health and mental health professionals who are currently treating you. Your signature on this Agreement is written, advance consent for me to release information to these professionals. A record of any disclosures will be kept in your Clinical Record.

_____ **Check here if do NOT wish us to release any information to other mental health and health professionals who are currently treating you**.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT, AGREE TO ITS TERMS AND HAVE RECEIVED THE HIPPA PRIVACY NOTICE DESCRIBED ABOVE.

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Client or responsible party Date

□ I hereby consent for Stephanie Collier, LCSW License #3581-C

□ I hereby consent for Millie Lace, MSE, LPC License #POO11032

□ I hereby consent for Bart Michael Smith, LAC License #A1307071

to provide treatment to me in accordance with the Code of Ethics and Standard of Practice as adopted by the American Counseling Association and the Arkansas Counselor's Association. The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients. It is the responsibility of the client to work jointly with the counselor in devising integrated, individual counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients. Counselors and clients regularly review counseling plans to ensure their continued viability and effectiveness, respecting clients' freedom of choice.

□ I hereby consent for treatment using Technology-Assisted Counseling in addition to Face to Face. I have read, understood, and signed the additional informed consent for Technology-Assisted Counseling.

□ I understand counseling sessions may be videoed for supervision/consulting purposes and will be used only to facilitate treatment.

_____ _____

Signature of Client/Person Authorized to act in behalf Date

Fees for Counseling, Financial Agreement & Assignment of Benefits

I understand that the counseling services I will receive will be contracted through Concepts of Truth, Inc. I understand that I am personally responsible for the cost of services that I will receive from Concepts of Truth, Inc. and that I may use a third party source to satisfy my bill. However, fees for services are supplemented by public support and will be determined by a sliding scale.
The standard fee for a 50 minute counseling session is $125 per session. A session is generally 50 minutes in length with 10 minutes for record keeping. Longer sessions are charged as a prorated fee. Indirect services such as treatment planning, case management or other forms not directly performed with client present additionally may be charged to client. In the event of any court subpoena, fees will be charged for counseling services as appropriate. Some proof of gross annual income may be required to be placed on the sliding fee scale for face to face sessions only. This may be an income tax return, a paycheck stub or some other proof of income. There is no sliding scale for distance or technology-assisted counseling.

Concepts of Truth, Inc.
Session Fee Sliding Scale

Gross Annual income	Fee
$ 0 - 25,000	$ 75.00
25,001 - 32,500	85.00
32,500 - 37,500	95.00
37,501 - 50,000	105.00
50,000 - 60,000	115.00
60,000+	125.00

Fee Agreement

_____ Fee for one session _____

PAYMENT ARRANGEMENT:

All fees are payable in full at the time of service. Established clients may be offered an account arrangement at the discretion of Concepts of Truth, Inc. Payment may be made in cash, by check, or by money order or credit card. I understand that if using a credit card, I will additionally be charged a $2.95 processing fee. I hereby authorize payment directly to Concepts of Truth, Inc. from any third party provider for services received. I understand that I am financially responsible for charges not covered by this authorization.

I have read and understood the above fee agreement, and I agree to abide by its terms.

_____ _____ _____
Client/Person Authorized to act in behalf Date Signature of Therapist